VSH Futures Advisory Committee
May 15, 2006 2:00 – 4:30 PM

Minutes

Next committee meeting: June 26, 2006 2:00 to 4:30 PM Skylight, Waterbury

Present

Advisory Committee Members: Conor Casey, VSEA; Larry Thomson, VSH; JoEllen Swaine, VSH; John Malloy, VSH/HCHS; Anne Jerman, VSH; Jackie Leman, client, peer support worker at Westview House-HCHS; Stan Baker, DS Clinical Director (HCHS) and DD Council; Jack McCullough, MHLP; Gregory Miller, M.D., VPMA, Retreat Healthcare; Sally Parrish, advocate; Diane Bogdan, DOC; Larry Lewack, NAMI-VT; Linda Corey, VPS, Inc.; Ed Paquin, VP&A; Kitty Gallagher, Adult Standing Committee; Ken Libertoff, VAMH; Michael Hartman, WCMH; David Fassler, VPA; Michael Sabourin, advocate, consumer, parent; Xenia Williams, VSH consumer, WCMH staff; Bea Grause, VAHHS; Paul Dupre, WCMH, for VT Council of Devel and MH Services; Nick Emlen, VT Council, representing Jeff Rothenberg; Peter Thomashow, CVH; Bob Pierattini, FAHC/UVM; Sandra Steingard, HCHS;

Guests:
Julie Tessler, VT Council; Maria Baseau, Retreat Healthcare; Scott Thompson, CRT; Bruce Spector, BISHCA; Roy Riddle, WCMH; Eldon Carvey, reporter Counterpoint; Floyd Nease WCMH; Maureen Mayo, VT Ctr for Independent Living.

Staff:
AHS Secretary Cindy LaWare; AHS Deputy Secretary Steve Gold; VDH Deputy Commissioner Paul Blake; Beth Tanzman; Judy Rosenstreich; Dawn Philibert, VDH/DMH; AAG Wendy Beinner; AAG Kristen Chandler; and Mike Kuhn, Principal Architect, VSH Futures Project, BGS.

Opening Remarks from AHS Secretary Cynthia LaWare

AHS Secretary Cynthia LaWare opened the meeting by noting this will be the 4th meeting she has attended and shared her perspective on the Futures planning process, the advisory role of the committee, and how together we can move the Futures Project forward.

All of us have worked extremely hard. We now have a plan that the legislature has approved. While taking pride in accomplishments to date, we must keep our eye on the goal to fully implement the Futures plan.

The Secretary commented on four different leadership styles and offered that her preferred style is consultative.

Secretary LaWare also shared her commitment to the values of respect and integrity, and her absolute commitment to excellence. These values will guide her actions.

She expressed the hope that if we do disagree, we do so respectfully. Once a decision is made, we should all come together, accept that portion of the decision, and move forward on implementation.

As we move forward, the staff will prepare results-oriented agendas and the process will be as transparent as can be. The Secretary advised that information about community projects, for example, will have to be sequenced as communities may need to hear about issues and plans before others.

Our challenge now is to move forward with as much focus as we can for those Vermonters who are counting on us to bring online a new facility to serve them. The Secretary will rely on the advice and counsel of the Advisory Committee process as she discharges her responsibilities as head of the Agency of Human Services. She thanked everyone for their participation and hard work.

Draft Actuarial Report from Milliman, Inc.

Beth opened discussion on the draft actuarial report, requesting the committee's input in two areas. First, what additional content should be included to make the study stronger, and, second, how do members feel about the recommended bed capacities. She distributed copies. Beth pointed out that the draft report is not fully responsive to the specifications of the agreement that we have with Milliman in three important areas:

- Corrections projections are not included.
- Analysis of clinical trends, utilization rates for comparable systems, and inpatient funding trends is not sufficiently supported by comparative and benchmark data.
- The scenario for full implementation accounts for only 10 sub-acute beds and five crisis beds rather than the planned 16 sub-acute and 10 crisis beds.

Ken suggested that we ask clinicians to look at this report, weight it against our own background data, apply their on-the-ground experience, and come to a resolution.

Bea Grause agreed that lack of analysis for Corrections is a real concern. Beth clarified that Milliman did consider Corrections but did not describe their findings.

David Fassler reminded us that the Advisory Committee's original number, presented to Charlie Smith, was 40 beds; this number was reduced to 32 beds.

In addition, David offered that Milliman may not have know these two things:

- Springfield hospital has reduced its available beds from 19 to 10
- Sub-acute programs will be voluntary.

David had not previously heard the term "woodwork effect" but felt that it is a legitimate assumption. He stated that we need to take Milliman's conclusions seriously. They are telling us that we are off by 50 percent in our projections.

Xenia Williams expressed concern that VSH runs on a one-size-fits-all basis. Instead, we need to have individualized mental health treatment. As some patients at VSH are not willing to go anywhere else, treatment would have to be individualized to meet their needs. Xenia made a number of suggestions aimed at building flexibility into the system.

Paul Dupre judged that a range of 48 to 54 beds is a reasonable recommendation given that we have operated VSH at this level for several years, adding that this is probably a better figure than 32 beds. The higher numbers of 64 to 70 beds make sense if we do not provide the resources to sustain the whole system of care. Furthermore, any part of our system that is left out / not funded impacts the whole system.

Conor Casey asked if the actuary could make valid projections beyond 2016. He also questioned whether the residential programs as proposed will have as much impact on the VSH census as planned.

Larry Thomson spoke of the importance of both parts of the public mental health system---inpatient and community---questioning whether a privatized hospital might cost more than one operated by the state. He also asked if the study may have underestimated population growth. Larry cited Maine's experience in building capacity for 48 civil and 44 forensic patients, now appearing to be inadequate based on projected admissions. New Hampshire expects growth in need for inpatient capacity.

Jack McCullough offered another perspective, referencing an overlap in the two major topics before us today: the actuarial report and the coercion issue. He offered that the projected growth in inpatient capacity in Maine and New Hampshire may stem from shortcomings in those states' obligations under Olmstead.

Ed Paquin spoke of the substantial number of people in Corrections custody who should have access to VSH but currently do not. He sees a community system under stress and difficulty accessing care. Unless the community system continues to grow with sustainable funding, demands on involuntary inpatient care will increase.

Public comment → We need to document the number of beds needed and for whom.

Michael Hartman appreciated the concept of the "woodwork effect" but challenged the comparisons made to Maine and New Hampshire. Their community systems are significantly weaker than ours. Vermont relies less on hospitalization than other states.

Public comments →

- What capacity are we at in the current hospitals?
- How many beds do we have now? How are they being used? Lack of staff may make some of this capacity unusable.
- What is the caseload? What should it be?

Larry Lewack brought up incidence rates, citing a figure from John Pandiani, VT Dept. of Health/DMH, of 25,000 Vermonters with serious mental illness. According to federal definitions, 8.6 percent of the adult population has mental illness. This would translate to 41,000 Vermonters based on the state's population. What did Milliman use and how may it have been translated for Vermont?

Linda Corey stated that the Rutland Regional Medical Center is trying to serve people in their hospital who otherwise would have to go to VSH.

Discussion of Milliman's draft report concluded with the understanding that AHS will take the input from the Advisory Committee, press Milliman to complete its analysis of areas not fully addressed, and seek further input on the issue of planning an appropriate level of inpatient capacity.

<u>Reducing Coercion and the Programs in the Futures Plan:
Practical Steps to Realize Our Vision</u>

Wendy Beinner stated that the committee should discuss implementation of Act 114 beyond the current VSH.

Nick Emlen offered that we are working toward a system of no coercion. Like world peace, we all want it yet we are not structuring our day-to-day actions around this goal. Nick advised that it is more useful to attach voluntary or involuntary treatment to the individual, not to the program or facility. We should ask the question, voluntary or involuntary, in the context of an individual's plan of care, not about facilities.

Sandy Steingard advised that we already do ask, "Is this the least amount of coercion?" every step of the way. Testifying in court, she must justify her actions and recommendations. She noted that the biggest forces towards reducing coercion are financial. We're already there in terms of minimizing hospitalization.

Xenia said that people at Home Intervention have to agree to be there. If we had a philosophy of focusing on the individual, we could help people recover without coercion. The therapeutic relationship we have with people works best.

Michael Sabourin stated that voluntary service can and should be provided at VSH, not just in the community.

Linda Corey commented that many people are traumatized by involuntary care. Also true is that people in the community are glad to have their medication brought to them so they don't have to remember.

Larry Lewack presented a framework for further consideration of this issue. A matrix to show the spectrum from Least Restrictive (LR) to Most Restrictive (MR) in each setting----Diversion, Designated Hospital, VSH, and Corrections----would identify factors such as legal status, choice and RCIT (reducing coercion and involuntary treatment) in each of these settings.

LR ←----------→ **MR**

	Diversion	**Designated Hospital IN OUT**	**Vermont State Hospital VSH**	**Department of Corrections DOC**
Legal Status				
RCIT Reducing Coercion and Involuntary Treatment				
Choice in each of these settings?				

Responses to the matrix included:

- A suggestion that Wendy Beinner and Jack McCullough, who are familiar with the law, do a presentation.
- The matrix could provide the CRR and Care Management work groups with clear direction from the Advisory Committee.
- As much *choice, *input, and *control as can be defended, as possible in the community, when there is going to be a public safety issue, you have to move toward coercion. Most programs could probably do the whole range.
- What's the range? Is it possible that somebody in this program is on an ONH? Or will all of the people in this program be voluntary? What's the *legal* range? What effort will the program make to reduce coercion?

Jack McCullough commented on two issues:

1. Use of designated hospitals—We thought these would reduce VSH census but it only increased involuntary beds and therefore increased coercion. Should we really be using the designated hospitals to replace VSH?
2. Outpatient commitment uses coercion but this helps because it reduces the number of people being locked up in hospitals.

Gregory Miller offered that legally voluntary patients certainly can be subjected to coercive treatment, strategies and mechanisms.

Paul Dupre offered that it is counterproductive for an individual to have involuntary meds at VSH and to come out to a community setting and have to be voluntary, falling off the use of medication and then needing to be re-hospitalized. He concluded that community residential programs may appropriately continue involuntary medication orders but not initiate them.

Ed Paquin suggested that VSH patients going in to community programs may carry with them involuntary forms of treatment. He added that there is so much of an unmet need in the community that you're not going to have room in the CRR's unless you *restrict* them to VSH patients. Otherwise, we will not reduce the VSH census.

In conclusion, Beth will develop a way for the Advisory Committee to work on / react to the framework presented by Larry Lewack.

Work Group Reports

VSH Employees Work Group Conor reported on the group's ongoing work to identify a range of options for transitioning state hospital employees to a new inpatient program to replace VSH. These include an inpatient facility operated by either a public, private, or public/private management and staffing model or some combination thereof. Conor discussed how the work groups operate, specifically that any member of the Advisory Committee may participate in a work group. He offered VSEA's concern that the original membership of this work group, consisting of individuals representing management and labor, should be retained to ensure a balance of interests when the group is ready to make its recommendations.

- Conor Casey moved / Larry Thomson seconded that the voting membership of the VSH Employees' Futures Work Group will be based on its original design to maintain equal representation of labor and management when the group is developing its recommendations with the understanding that Advisory Committee members are otherwise welcome to attend and to participate in discussion.

Discussion began with Ed Paquin who first noted that all work groups are advisory and this whole group is advisory. Further, the motion implies that this is where the labor

issues will be hammered out. He added that if we're looking to create a system that is staffed the best way for consumer needs, then this isn't the best way.

Xenia Williams questioned whether there should be another work group to consider staffing of CRR programs given that VSH employees have higher wages and benefits than employees in community programs. Is one group being valued by the state while another part of the system is being neglected, she asked.

Bea Grause agreed with Ed that setting up an adversarial process is not desirable if, in fact, the issues are broader that just labor matters.

Linda Corey agreed with Xenia, adding that in the everyday world when businesses change, people change and affected workers are offered retraining. She also mentioned that the consumers at Safe Haven are performing a lot of services performed at VSH.

David Fassler asked if there is a mid-point that would allow anyone to be on a committee but if there is a specific labor issue it could be equal representation.

Ken offered that this vote should not be taken as an insensitivity to VSH employees.

Seeing that there was no further discussion, Beth clarified that the VSH Employees' Work Group is not a labor-management committee and responded to a call for the vote.

- The motion made by Conor, seconded by Larry T. was voted on, as follows:
  Favor 11 Opposed 6 Abstentions 6

Michael Sabourin requested a ruling on the outcome of the vote, offering his judgment that the result was a negative vote on Conor's motion. Beth said she would check on Roberts' Rules later, if that was okay with the group. No objections.

Housing Development Work Group Ken, who is leading this work group, emphasized the high priority of housing to the success of the Futures plan. Its purpose is to take a visionary look at how we can develop both a short and a long-term perspective and recommendations on housing.

He asked for input from consumers and family members as well as specific groups. The work will take place over four meetings on June 19, July 11, August 22, and September 26…all from 2:00 to 4:00 in the 4th floor conference room of the Pavilion Building, Montpelier. The findings and desired next steps will be reported at the VAMH annual meeting on October 30.

Ken also shared the outcome of the Advisory Committee's recommendation that $150,000 be appropriated to the housing contingency fund in FY 2007. The legislature appropriated $90,000.

Community Residential Recovery Work Group Michael Hartman gave a brief, positive update on progress for developing the Autumn Harvest Inn in Williamstown. The Act 250 process is nearing completion; renovation could begin in 30-40 days. People in town have been inquiring about jobs.

Care Management and Crisis Beds Work Groups The committee postponed updates on these work groups until the next Advisory meeting.

Other Business and Public Comment

Linda Corey asked for an 800 number to participate by phone in some work group meetings. Xenia Williams thanked Ken for his sensitivity to people who have experienced homelessness or involuntary treatment.

The meeting adjourned at 4:30 PM.

SUBMITTED BY: Judy Rosenstreich
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